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FISCAL IMPACT STATEMENT

LS 6852
BILL NUMBER: HB 1572

NOTE PREPARED: Feb 21, 2009
BILL AMENDED: Feb 19, 2009

SUBJECT: Medicaid Managed Care.

FIRST AUTHOR: Rep. Welch
FIRST SPONSOR:

BILL STATUS: CR Adopted - 1st House

FUNDS AFFECTED: X GENERAL
DEDICATED
X FEDERAL

IMPACT: State

Summary of Legislation: (Amended) This bill requires the Office of Medicaid Policy and Planning (OMPP) to establish a uniform prescription drug formulary to be administered by a managed care organization that contracts with OMPP to provide services under the Medicaid program.

The bill requires payment for services under the Medicaid program in a hospital setting to be based on the individual's presenting symptoms and the services required to triage, diagnose, and treat the individual.

The bill prohibits the denial of payment for services that are medically necessary solely because the provider did not obtain prior authorization in a timely manner.

The bill also requires the Health Policy Advisory Committee to study and make recommendations on certain topics.

Effective Date: (Amended) Upon passage.

Explanation of State Expenditures: (Revised) *Health Policy Advisory Committee:* The bill specifies that the chairperson of the Health Finance Commission is to annually select a chairperson of the Health Policy Advisory Committee. The bill specifies that the Health Policy Advisory Committee is to be appointed by June 1, 2009, and is to make quarterly reports summarizing the committee's actions, findings, and recommendations on any topic assigned to the committee to the Health Finance Commission and to the Select Joint Commission on Medicaid Oversight. The 17-member Health Policy Advisory Committee is assigned 10 specific topics to study and make recommendations on before July 1, 2010. Committee members are entitled to salary per diem and

reimbursement for travel expenses. Legislative Council resolutions in the past have established budgets for interim study committees in the amount of $16,500 per interim for committees with more than 16 members, such as the Health Policy Advisory Committee.

(Revised) *Emergency Department Provision:* This bill would require OMPP and a Medicaid MCO to pay 100% of the Medicaid fee-for-service reimbursement rates for certain federally required screening exams provided by a physician in an emergency department. Emergency department physicians who have executed MCO provider contracts would be excluded from this provision. The bill also requires OMPP and Medicaid MCOs to pay hospitals for medically necessary screening services. The bill specifies that reimbursement is required to be made on the basis of the patient's presenting symptoms, not the final diagnosis. The bill also specifies that the OMPP or an MCO may not deny reimbursement for services that are medically necessary on the sole basis that the provider did not obtain prior authorization in a timely manner. The bill would result in increased costs to the state to the extent that any increased risk-based managed care costs would be passed through to the state in the annually calculated and negotiated MCO capitated rates.

OMPP has reported that within the fee-for-service program, the physicians' claims as well as the associated hospital emergency department claims are reimbursed. The fiscal impact of this provision will depend on MCO policy decisions and actions taken to control inappropriate use of emergency departments by their enrollees.

(Revised) *Standardization of MCO Prescription Drug Formulary:* The bill requires that the Medicaid MCOs adopt a uniform prescription drug formulary that is to be developed by OMPP. Changes in administrative processes concerning drug purchasing within the MCOs would involve costs that would either be covered within the existing contracts to be passed on within annually renegotiated rates or may require OMPP to amend the contracts. The bill requires OMPP to develop the uniform prescription drug formulary for use by the MCOs and specifies that OMPP is not required to use the current preferred drug list developed by the Drug Utilization Board. MCOs are required to adopt the uniform prescription drug formulary before January 1, 2010. The cost of this requirement will depend upon the final drug formulary developed for the MCO's use and the purchasing agreements negotiated by the individual MCOs. Any changes in the MCO cost would ultimately be passed through to the state via the MCO's negotiated capitation rates. The fiscal impact would depend on actions taken by the MCOs to implement this requirement.

(Revised) *Background Information:*

(Revised) *Health Policy Advisory Committee:* The 17-member Health Policy Advisory Committee is a statutory subcommittee of the Health Finance Commission. During the 2006 interim, the last time the 17-member Committee met, four meetings were held with an expense of $600. Legislative study committee budgets usually begin with each new fiscal year on July 1. With appointments required to be made by June 1, 2009, the potential exists for the Committee to meet before funds would be available to reimburse per diem and travel expenses. Additionally, the Legislative Services Agency provides staffing for the Committee.

Emergency Department: This bill provides for physician payments for federally required hospital emergency department screening exams. OMPP reports that federal MCO regulations require the MCOs to pay for screening exams performed on MCO recipients who meet a prudent layperson's definition of what constitutes an emergency condition. Current Indiana statute requires that physicians who are not contracted with the MCO (i.e., out-of-network providers) must be paid at 100% of the Medicaid fee-for-service reimbursement for medically necessary screening services for MCO patients who present at an emergency department with a

medical emergency.

This bill would require the payment for all specified screening exams without authorization of the enrollee's primary medical provider. Financially, this requirement would impact the three MCOs differently depending on the contracted status of the emergency department physicians if the organization is currently paying triage fees to contracted providers or denying the claims in total. The fiscal impact of this provision will ultimately depend on actions taken by the individual MCOs to control inappropriate use of emergency departments by their enrollees.

The Medicaid managed care program operates under a federally approved waiver. The regulation waived is the recipient's freedom of choice. MCO recipients select or are assigned a primary care provider to give the individual a "medical care home". The primary care provider is then responsible for that recipient's preventative and routine care. Controlling the cost of inappropriate use of emergency room services is one of the methods that MCOs use to control costs within the network.

Any denied payments occur within the capitated managed care contracts. The denial of payment does not represent a direct savings or cost to the state since the state pays a capitated amount for each MCO member month regardless of the cost incurred by the MCO for the member's care. The bill would result in increased costs to the state to the extent that increased risk-based managed care costs, which must be actuarially determined, would be passed through to the state in the negotiated rates for the CY 2010 capitation rate. Any fiscal impact related to this bill would be anticipated to result in higher capitated rates for calendar years 2010 and 2011.

The Medicaid program is jointly funded by the state and federal governments. The state share of program expenditures is approximately 36%. Medicaid medical services are matched by the federal match rate (FMAP) in Indiana at approximately 64%. Administrative expenditures with certain exceptions are matched at the federal rate of 50%.

Explanation of State Revenues: See *Explanation of State Expenditures* regarding federal reimbursement in the Medicaid Program.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: FSSA, OMPP.

Local Agencies Affected:

Information Sources: FSSA, Health Finance Commission meeting minutes and attachments, October 22, 2008; Social Security website.

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